Horizon NJ Health
Continuous Quality Improvement
2014 Program Description

I. Purpose
The Horizon NJ Health Continuous Quality Improvement Program goals are to systematically monitor, assess, track, trend and improve the quality of care, service, health status and safety of our members. The Continuous Quality Improvement (CQI) Program is comprehensive and has the resources, infrastructure and authority required to meet the program goals and objectives. Each year, the CQI program description is reviewed and revised if necessary, and an annual comprehensive workplan is developed and implemented. The CQI Program incorporates the mission and vision of Horizon NJ Health (HNJH).

In 2014, to improve the quality of care and life for our members, the HNJH CQI Program places significant emphasis on:

- Maximizing value in provision of healthcare services
- Increasing the safety and quality of healthcare delivered to our members
- Reducing healthcare disparities and increasing health literacy
- Educating members in regards to the Personal Preference Program
- Maintaining quality related reporting requirements of accrediting bodies and other local, state, and federal regulatory and external review organizations
- Maintaining compliance with regulatory and accreditation requirements

II. Scope
The scope of the membership served by the Continuous Quality Improvement Program includes:

- Aid to Families with Dependent Children (AFDC) Temporary Assistance for Needy Families (TANF)
- NJ FamilyCare - Uninsured parents and children
- SSI-Aged, Blind, Disabled (ABD)
- Division of Developmental Disabilities (DDD)
- Division of Child Protection and Permanency (DCPP)
- Family Care Advantage

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Managed Long Term Services and Support (MLTSS)

The CQI Program has two major components: clinical and service. The range of the clinical activities is extensive, encompassing preventive care, acute care, chronic care, behavioral health, and care provided to special populations, including the elderly. It monitors provider credentialing and compliance, member education, screening, clinical practice guidelines, HEDIS measures, continuity and coordination of care, delegation and medical record documentation. The service component of the program monitors accessibility of care, availability of care, appropriateness of care, member satisfaction, provider satisfaction and complaints from members or providers.

Audits are used to objectively monitor, measure, evaluate and trend the quality of clinical care and service delivered throughout the entire organization. CQI initiatives are based on measurable, data driven evaluations as determined by contract, regulatory requirements and accreditation standards and are implemented to improve the quality of care and service that HNJH provides to its members. Quality Management Department activities are coordinated and conducted in conjunction with other departments, as needed.

III. Objectives

The objectives of the CQI Program are to:

- Monitor the accessibility, availability, safety, quality of care and service provided to our membership on an ongoing basis.
- Employ strategies to motivate members to access and use services and tools to manage their care.
- Establish quality indicators for evaluating the services provided by the HNJH physician and healthcare provider network.
- Ensure compliance with NJ State Medicaid Contract requirements, all regulatory requirements and accreditation standards.
- Monitor and improve member and health care practitioner satisfaction.
- Maintain an ongoing oversight process for functions performed by delegated entities.
- Maintain a high quality provider/practitioner network through a formalized credentialing and recredentialing process.
• Continuously improve the quality of care, safety and services to members and providers.
• Decrease health disparities through increased health literacy and culturally sensitive interventions with respect to regulatory and accreditation standards.
• Optimize care delivery for our members with special and complex health needs.

IV. Clinical and Service Priorities

As part of its CQI program, HNJH monitors performance and seeks opportunities for improvement across the range of health care services that the organization provides. In order to choose meaningful clinical issues that reflect the needs of the membership, HNJH assesses the demographics, health risks and health care needs of its members annually and on an on-going basis. In addition to the results of this assessment, the clinical scope of the CQI program is also based on The New Jersey Office of Managed Health Care reporting requirements, Medicaid reporting requirements and HEDIS results. Currently, HNJH has identified the following meaningful clinical and service measures for its membership:

• Care for pregnant women
• Care for the member with asthma
• Care for the member with HIV or AIDS
• Care for the member with diabetes
• Care for the member with congestive heart failure
• Care for the member with cancer
• Care for the member with sickle cell
• Care for the member with end stage renal disease
• Care for the member with hypertension
• Care for the member with obesity
• Care of members with special needs
• Care for elderly members
• Care of members with depression
• Care for members with complex health needs
• Care for members with cognitive impairment
• Women’s and men’s preventive screenings - breast, cervical, prostate and colorectal screenings
• EPSDT services for children from birth to 21 years old

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- Preventive care
- Inpatient and ambulatory care services
- Over and under utilization
- Services identified for monitoring by the State of New Jersey Department of Human Services
- Member and physician satisfaction
- Availability and accessibility of care and services
- Lead screening
- Dental care
- Patient Safety
- Behavioral Health services
- Rehabilitative Services: Occupational, Speech, and Physical Therapy
- Neonatal Intensive Care Services
- Managed Long Term Care Services and Support
  - Medical Day Care
  - Personal Care Assistance
  - Maximizing Value in Provision of Healthcare Services

HNJH is committed to extending healthcare resources by maximizing value while providing services to its membership and providers, including but are not limited to:
- Increasing process efficiency through end to end process review & revision
- Monitoring trends and outcomes for hospital acquired conditions and serious adverse events
- Promotion and utilization of evidence based guidelines
- Supporting care delivery in the most appropriate setting
- Promoting generic drug utilization

V. Structure

A. Governing Body
HNJH is a wholly owned subsidiary of Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) and has been providing healthcare services to the publicly insured in New Jersey since 1994.

The Horizon Healthcare Board of Directors is the governing body and is accountable for the CQI Program. The Board has assigned responsibility for the

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full scope of the CQI Program to the Vice President Clinical Affairs and Chief Medical Officer of Horizon NJ Health. The Board reviews and approves the CQI Program Description annually.

The Senior Vice-President of HBCBSNJ, Chief Executive Officer (CEO) of Horizon NJ Health charges the CQI Program with improving clinical and non-clinical services. The Vice President, Chief Medical Officer (CMO) of HNJH, who has the credibility and authority to affect clinical practice, has overall responsibility for development and implementation of the CQI Program.

The Chief Medical Officer or designee chairs the CQI Committee, which approves monitors and evaluates the CQI program. The CQI Program is administered and managed by the Director of Quality Management (QM). The CMO, Senior Medical Director and Medical Directors are actively involved in coordinating the CQI Program throughout the entire HNJH organization.

B. Quality Committees

1. The Continuous Quality Improvement Committee (CQI) is an interdisciplinary committee, which is the delegated authority for the approval, monitoring and evaluation of quality improvement projects as well as the overall CQI program. One or more participating providers are included on the CQI Committee. The CQI committee meets no less than ten times per year and reports directly to the Quality Committee of Horizon Healthcare of New Jersey Inc. Board.

   The organizational structure supporting the implementation of the CQI program is defined through a description of Horizon NJ Health’s CQI committee, subcommittees and departmental responsibilities. Eight subcommittees report to the CQI committee. The purpose of each committee is outlined below:

   a. **Physician Advisory Committee** – The Physician Advisory Committee (PAC) meets quarterly, and the purpose is to identify issues of concern to the physician community and opportunities for optimizing patient care.
b. **Community Advisory Committee** – The Community Health Advisory Committee (CHAC) meets quarterly, and the purpose is to provide a vehicle for expert community review and advice on matters affecting Horizon NJ Health members as related to healthcare education, outreach and promotion.

c. **Pharmacy and Therapeutics Committee** – The Pharmacy and Therapeutics (P&T) Committee meets quarterly and is responsible for clinical support of the Horizon NJ Health (HNJH) Pharmacy Program.

d. **Administrative Policy Approval Committee** – The Administrative Policy Approval (APA) committee meets at least quarterly, and the purpose is to review and approve all Horizon NJ Health Administrative Policies and Procedures.

e. **Utilization Management Committee** – The Utilization Management (UM) Committee meets quarterly. The purpose is to ensure high quality, cost effective health care for the Horizon NJ Health membership, including those special needs members. The UM committee is responsible for reviewing, trending, and analyzing data concerning special needs members.

f. **Quality Peer Review Committee** – The Quality Peer Review Committee (QPRC) meets quarterly and reviews potential quality of care and service issues involving Horizon NJ Health members. The goal is to ensure that Horizon NJ Health members are receiving quality health care and excellent service.

g. **Member Provider Services and Satisfaction Committee** – The Member Provider Services and Satisfaction Committee is a mechanism to review the complaint and appeals process, capturing complaint and appeal data from initiation to resolution. This committee meets at least quarterly and focuses on tracking and trending member, physician and delegated vendor...
complaints in an effort to create proactive action plans throughout the company to address the identified issues.

h. Delegate & Vendor Oversight Subcommittee—The Delegate and Vendor Oversight Subcommittee (DVOS) is an interdisciplinary subcommittee that provides oversight of healthcare contracts and selected non-healthcare contracts. The committee meets monthly.

The organizational chart of the CQI committee is found in attachment A and a full description of each subcommittee is found in attachment B.

VI. Quality Management Staffing

A. Vice President, Clinical Affairs, Chief Medical Officer:
The Vice President, Chief Medical Officer (CMO) is responsible for the design and implementation of the CQI Program. The CMO provides quarterly reports to the Quality Subcommittee of the Horizon Healthcare of New Jersey, Inc. Board of Directors.

B. Director of Quality Management:
The Director of QM reports to the CMO and is responsible for the planning and directing of the Continuous Quality Improvement Program. In conjunction with the Administrative Services Department, the Director oversees delegate and vendor compliance and monitors the credentialing and recredentialing processes performed in the corporate office. The Director oversees the development of the annual work plan, produces the annual quality program evaluation and program description and participates on all CQI subcommittees.

C. Senior Medical Director/Medical Directors/Dental Director
The CMO, or designee, chairs the CQI Committee and sits on all CQI subcommittees. The Medical Directors and Dental Director provide support to the Quality Management department in its evaluation of clinical and service monitoring including, but not limited to, complaints, quality referrals, and corrective action plans.

D. Quality Managers

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The managers within the Quality Department report to the Director of Quality Management and supervise the routine operations within their scope of accountability including member/provider complaints, quality peer review process, state audits, HEDIS hybrid collection, quality improvement activities, policy and procedure revisions, focus studies mandated by the State of New Jersey, state contract compliance, corrective action plans, accreditation and regulatory compliance activities and member safety education. They assist in the ongoing evaluation of the CQI plan and manage clinical and non-clinical staff.

E. Health Data Analyst
The Health Data Analyst performs research, analysis, programming, implementation and coordination ensuring accurate, timely reporting for the Quality Management Department. The responsibilities include but are not limited to:

- Analyze reporting needs, uses available data and various methods of data retrieval to develop databases and reports that are responsive to department needs.
- Review and coordinate all data requests to ensure data consistency and accuracy.
- Utilize various software packages to extract and analyze data.
- Provide support and education to all Health Services departments on data requirements and needs for quality activities.

F. Quality Management Staff
The Quality Management Department includes clinical (Registered Nurses, and Licensed Practical Nurses) and non-clinical staff. Staff responsibilities include but are not limited to the following:

- Monitoring quality improvement activities
- Conducts HEDIS hybrid chart review
- Monitor compliance with: medical record review for Primary Care Physicians (PCPs) and Specialists, Early Periodic Screening Diagnostic Treatment (EPSDT), 24 Hour Access, and Appointment Availability
- Prepare documents for external peer review audits and on site visits
- Oversee the quality referral process
- Assists with quality reporting to CQI and State agencies
- Assist with NCQA accreditation processes and submissions
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- Monitor delegates and participates in annual audits of delegates
- Prepare CQI Committee materials and minutes
- Prepare Quality Peer Review Committee (QPRC) materials and minutes
- Assist with policy and procedure development and implementation
- Monitoring of credentialing and recredentialing activity

G. Complaint Management Staff
The complaint management staff is composed of clinical and non-clinical staff members who handle all complaints. The complaints staff is responsible for handling all member and provider complaints/grievances in accordance with the New Jersey State Medicaid Contract requirements and other applicable regulatory and accreditation standards.

VII. Resources
All departments within HNJH contribute to the CQI Program. Included is the Clinical Affairs Department, which is comprised of Special Needs, Utilization Management, Care/Case Disease Management, Outreach, Managed Long Term Care Services and Support, Pharmacy Services, and Quality Management. Other departments involved include the Executive Department, Healthcare Administration, Professional Contracting and Servicing Department, Vendor Services Management, Project Management, Regulatory Affairs and Compliance, Marketing and Communications, Administrative Services, Human Resources, Informatics, Medical Economics, Finance and Information Technology. In addition, consultants are available to the Program to provide activities such as statistical analysis and quality improvement design.

VIII. Quality Management Functional Areas

A. Care and Service Monitoring
Audits are conducted to assess the adequacy and appropriateness of care and service provided to the membership based on standards of care as well as Medicaid Contract specific care and service criteria and accreditation standards. This includes the monitoring of availability, accessibility, quality and continuity of care on an ongoing basis. Audits performed include evaluation of Early Periodic Screening Diagnostic Treatment (EPSDT) services for children and medical record review of primary care
physicians and specialists. The auditor provides immediate feedback to the office including copies of audit standards, education for improving documentation and the opportunity to discuss preliminary results. Healthcare Providers who do not meet performance standards are required to submit corrective action plans. Follow-up visits and re-audits are conducted to monitor for improvement. Providers that fail to improve may be referred to the QPRC.

In addition, audits are conducted on case management activity specific to the Lead, DDD, and DCPP populations. All audit results are analyzed, trended, reviewed, and discussed with interdepartmental staff to identify opportunities for improvement including educational opportunities for the network. Annual results are presented in aggregate to the CQI committee and discussed with input from network practicing physicians and all committee participants.

B. Healthcare Effectiveness Data and Information Set (HEDIS)
HEDIS effectiveness of care measures are evaluated annually. HEDIS administrative results are reviewed monthly and analyzed. Changes and/or enhancements to initiatives and outreach activities are implemented if indicated. The HEDIS monitoring results are reported annually to the State, to the CQI committee, to NCQA and to the Quality Committee of the Horizon Healthcare Board.

C. Member Satisfaction
The Consumer Assessment of Health Plan Providers & Systems (CAHPS)survey) for adults, children and children with chronic conditions is conducted for HNJH through a certified vendor. Additionally, Adult and Child Member Satisfaction Surveys are conducted annually by the state. HNJH analyzes all survey results. In addition, HNJH conducts member focus groups and has implemented a Member Advisory committee. Areas that need improvement are identified and appropriate interventions are developed to enhance plan, practitioner and provider performance in order to improve member satisfaction. Follow up studies and ongoing monitoring is performed to ensure the effectiveness of the interventions.
D. Provider Satisfaction
HNJH conducts focus groups and an annual Physician Satisfaction Survey. Survey results are reviewed and evaluated. A satisfaction improvement work plan is developed and is implemented to address the identified issues. Complaint information is reviewed to evaluate and identify root cause issues and appropriate follow-up activities are implemented. The MPSS committee affords another opportunity for discussion of physician complaints to identify root cause and potential interventions to address the identified areas of concern. HNJH Professional Services and Contracting Department also conducts Office Manager Seminars and new provider orientation.

E. Complaints
The complaints team addresses member and provider complaints within the mandated timeframes required by the NJ State Medicaid Contract, Health Maintenance Organization (HMO) regulations and applicable accrediting bodies. The staff receives complaints through telephone calls initiated in the member/provider services area, State referrals, internal and external direct calls, written correspondence, HNJH websites and through the electronic internal complaint form. The internal complaints process provides the opportunity for all employees within the organization to document any complaint that was received during an encounter with a member and/or provider. The complaints staff is the liaison for complaints related to any delegate or vendor. As necessary, the complaints staff participates in the monthly meetings with delegates to ensure complaints processes are in compliance and to discuss any issues that may arise. Weekly reports documenting all complaints received the previous week are distributed to all executive and director level staff for review and follow-up. Medical Directors review and approve all complaint resolutions.
Complaint data is compiled and analyzed monthly and submitted quarterly to the CQI Committee and the Quality Committee of the Horizon Healthcare of New Jersey Inc. Board for review and discussion. Reports are prepared and submitted to the State as required in the Medicaid Contract.

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F. **Quality of Care Concerns & Serious Adverse Events**
Quality Management provides ongoing education to HNJH personnel regarding potential quality of care concerns and serious adverse events and how to refer issues to the QM Department for investigation and Medical Director review. All appropriate quality of care concerns and serious adverse events are presented to the QPRC for discussion, determination of departure from quality standards and guidelines and possible practitioner sanctioning. QPRC determinations are forwarded to the provider’s credentialing file. Sanctions are tracked and trended. Entities receiving sanctions may be monitored through telephonic and medical record audits and on site visits. Corrective action plans are monitored for compliance. The QPRC reports to CQI on quality of care concerns and serious adverse events.

In an effort to promote safety for hospitalized patients and in accordance with the Centers for Medicare and Medicaid Services (CMS), New Jersey law and the State Medicaid Contract, HNJH has a policy for hospital-acquired conditions selected by CMS and the State of N.J and also a Serious Adverse Events Policy. The QM department will review the NJ State Medicaid contract, CMS recommendations, applicable NJ State laws and guidelines at least annually, revising the policy and list of selected hospital-acquired conditions as necessary to reflect regulatory changes.

G. **Credentialing/Recredentialing**
The credentialing and recredentialing activities are performed by Horizon BCBSNJ Credentialing Committee. The HNJH Quality Management staff has responsibility for monitoring the credentialing/recredentialing processes for the HNJH network, which includes physicians, healthcare professionals, ancillary services, medical day care facilities, personal care assistance agencies and hospitals. There is monitoring of sanctions, limitations on licensure, utilization management, complaints, potential quality of care or access issues and timeliness of credentialing and recredentialing as part of the oversight process.

H. **Accreditations**

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HNJH is an accredited Health Plan by the National Committee for Quality Assurance (NCQA). The Quality Management Department continuously monitors compliance with NCQA Health Plan Accreditation standards.

IX. Operations

A. Clinical Practice Guidelines

Evidenced based guidelines are clinical standards that guide our practitioners and members to make appropriate health care decisions. These include, but are not limited to, preventive health, asthma, diabetes, maternity, EPSDT and geriatric care. The clinical practice guidelines are based on nationally recognized medical association standards and medical references. The guidelines are reviewed and updated at a minimum of every two years or as needed and presented to the CQI committee for approval. Guidelines and updates are made available to all appropriate practitioners and providers through the HNJH Physician Manual and the HNJH website. Guidelines are available to members through the website and/or a copy can be requested by calling the Member Services Department.

B. Patient Safety

Promoting patient safety for the membership is a key focus for HNJH and involves a wide range of activities. QM is a contributor and/or coordinator of safety initiatives performed throughout the organization.

1. Quality Management

➢ Coordinates safety activities performed throughout the organization
➢ Assists with reporting quality indicators to the provider network
➢ Monitors and follows up on corrective action plans required from network providers who had identified care and/or service deficiencies
➢ Conducts quality review process that collects, analyzes and trends data related to member safety issues and provides direction for improvement
➢ Researches complaints related to safety issues, and if appropriate, follows the peer review process and follows up on committee recommendations

➢ Coordinates response to urgent/immediate threats to members/operations

2. Pharmacy

➢ Performs drug utilization review via a dedicated Point of Sale (POS) DUR module: monitor early refill, drug-to-drug interaction, drug over usage, drug-disease contraindications. Concurrent review occurs at the time the prescription is filled; hard edits are in place specific to drug interactions “forcing” review by the pharmacist.

➢ Conducts over-utilization activities, including monitoring maximum daily dose and length of drug therapy as appropriate.

➢ Maintains Lock-in Committee: process of identifying at risk members who have a history of drug over-utilization, multiple physicians, multiple pharmacies and/or care coordination concerns. This process results in multiple internal referrals to disease management, Care Case Disease Management and case management programs to assist in monitoring medication usage and directing members to utilize only one pharmacy.

➢ Performs retrospective drug utilization review: identify seemingly suboptimal utilization through drug use evaluation, with effective outreach to prescribers/members with clinically appropriate detail.

➢ Pharmacy Case Management: Outreach and education provided to prescribers with regard to identified suboptimal member drug utilization.

3. Care/Case Management, Outreach and Special Needs Case Management

➢ Provides education to members through telephonic outreach and mailings related to preventive health activities and safety issues.

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➢ Provides education to members in Care Case Disease Management programs and conducts risk assessment to assist in identifying potential safety issues and addresses them through education and/or referral to appropriate case management or pharmacy management programs.

4. Managed Long Term Care Services and Support
➢ Performs face to face functional assessments in the member’s home and medical day care facilities and ensures services are provided in a safe environment.
➢ Identifies risks associated with Activities of Daily Living (ADL’s) and develops care plans to address gaps in care and services.
➢ Evaluates potential safety issues related to disease states, and makes appropriate referrals to care management programs and community resources.

5. Marketing and Communications
➢ Provides patient safety articles for distribution through member and provider newsletters.
➢ Ensures safety information is provided in the Member handbook and on the HNJH web site.
➢ Distributes information to members that facilitates informed decisions based on safety.
➢ Distributes education to members in the community utilizing interactive tools such as Lead Story Boards.

6. Utilization Management
➢ Identifies non-compliant members and refers to Care Case Disease Management and pharmacy management programs for assistance.
➢ Reviews discharge planning activities and assists with providing equipment/home care to ensure a safe home environment.
➢ Through the concurrent review process identifies potential “safety issues” of inpatients and forwards to quality referral process for investigation.

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Appeals staff handles all member/provider utilization management and medical appeals in accordance with the NJ Medicaid contract requirements, applicable regulations and accreditation standards.

7. **Medical Directors/ Dental Director**

➢ Discuss with facility physicians, network physicians and dentists any identified or potential quality of care or safety issues discovered through review of quality complaints or other measurement activities.

➢ Forward information to the quality referral process for investigation.

➢ Review and approve corrective action plans submitted by physicians, dentists, facilities, ancillary providers and other healthcare professional, and dentists who had deficiencies noted through audit or peer review process.

X. **Delegation Oversight**

HNJH conducts oversight of activities delegated to subcontractors and vendors through the Delegate Vendor Oversight Department and the Delegate Vendor Oversight Sub-committee. A mutually agreed upon Delegate Oversight Agreement exists which describes the responsibilities of HNJH and the delegate, the activities delegated, the frequency of reporting to HNJH, the process by which HNJH evaluates the delegate’s performance and the remedies, including revocation of the delegation, if the delegate fails to fulfill its obligations.

Prior to delegation of any activities, HNJH assesses the delegate’s capacity to perform assigned activities. As part of the oversight agreement, HNJH reviews and approves the delegate’s quality improvement program description and quality improvement work plan annually.

Delegate and vendor oversight activities include oversight of contracted vision, dental, laboratory, mental health services, radiology, and pharmacy claim processing. Keystone Family Health Plan serves as a delegate for claims, enrollment, family planning and member/provider services.
The Delegate Vendor Oversight Committee meets ten times per year to review and oversee delegate activities, issues and outcomes. Administrative Services, Quality Management, Professional Contracting and Servicing, vendor representatives and other HNJH staff attend the meetings as needed. A HNJH Health team conducts an annual evaluation to determine whether the delegate’s activities are being conducted in accordance with applicable accrediting body standards and the requirements of HNJH.

XI. Behavioral Health
Horizon NJ Health provides mental health/substance abuse services to a specific membership; this benefit is limited to the enrollees who are clients of the Division of Developmental Disabilities. This service is delegated to and provided by Value Options, a Managed Behavioral Healthcare Organization (MBHO). The HNJH staff works in collaboration with Value Options to provide quality care and service to this membership. A board certified behavioral health practitioner has oversight and accountability for behavioral health aspects of the CQI program. A behavioral health practitioner participates on the CQI, Utilization Management and Pharmacy & Therapeutics Committees to provide information and guidance on mental health/substance abuse topics and related quality initiatives and activities. The Delegation Oversight Department, the Quality Management Department, the Care Case Disease Management Department, and Utilization Management Department provide oversight of Value Options through reporting activities and monthly meetings. Information is reported to CQI on a quarterly basis. Value Options presents their program evaluation and program description annually to the HNJH CQI Committee. HNJH approves and adopts the Value Option Quality Program Description on an annual basis.

XII. Dental Program
Horizon NJ Health delegates the provision and administration of dental services for members to Scion Dental. The HNJH Quality Management and Health Services as well as Professional Contracting and Services staffs work in collaboration with Scion to provide quality care and services to our membership. Network dentists participate on the Dental Special Needs, Oral Health Advisory, Physician Advisory and Pharmacy & Therapeutics Committees and provide information, guidance and ideas relating to oral health topics and related quality initiatives and activities. The Administrative Services Department and the

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Quality Management Department provide oversight of Scion through reporting activities and monthly meetings. Information is reported to CQI on a quarterly basis. Scion Dental will present their program evaluation and program description annually to the Horizon NJ Health CQI Committee.

XIII. Cultural Competency and Health Literacy
HNJH recognizes the cultural diversity and health literacy needs of its health plan members and is committed to promoting cultural competency, increasing health literacy and decreasing healthcare disparities. HNJH utilizes data from multiple sources including the State of New Jersey to develop and implement policies and programs to increase cultural competency and health literacy. Education is provided to staff and participating providers to enhance the provision of culturally competent and linguistically appropriate care. Language assistance services, including bilingual staff and interpreter services are offered and provided to members at no cost. Production of patient-related materials which are easily understood and in languages to meet member needs is a HNJH priority.
In evaluating cultural and linguistic needs, HNJH performs the following:

A. Identifies language needs and cultural background of members, including prevalent languages and cultural groups, using U.S. Census data, enrollment data, member feedback and complaint data;

B. Identifies languages and of practitioners in provider network to assess whether they meet members’ language needs and cultural preferences; and

C. Adjusts the practitioner network if the current practitioner network does not meet members’ language needs and cultural preferences.

XIV. External Quality Review
On behalf of the Department of Medical Assistance and Health Services (DMHAS), the Island Peer Review Organization (IPRO), conducts oversight activities of HNJH. Annually, IPRO conducts an assessment of operations to determine if HNJH has implemented and operationalized state mandated contractual requirements. Additional oversight activities include focused studies and audits to evaluate the quality of care received by the publicly insured enrolled in managed care and the evaluation of Quality Improvement Projects (QIPS), Identification and Management of Adolescent Medicaid Members in the State of New Jersey.

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In addition, the QM Department maintains compliance with NCQA Healthplan accreditation standards.
The QM Department is responsible for developing, monitoring and evaluating the results of the studies for potential areas of future quality improvement activity.

XV. Fraud, Waste, and Abuse
Horizon NJ Health’s Fraud Waste and Abuse Prevention Plan (Plan) documents the organization’s comprehensive approach to prevent, detect, investigate, recover, and report cases of fraud, waste, and abuse in the Medicaid and NJ FamilyCare Programs. HNJH’s Plan supplements all Horizon BCBSNJ and HNJH policies and workflows on fraud, waste and abuse prevention and provides a framework for monitoring compliance with the following fraud waste and abuse related requirements:

- NJ Medicaid Contract
- Federal False Claims Act
- Patient Protection and Affordable Care Act of 2010
- Social Security Act
- Federal Program Fraud Civil Remedies Act,
- New Jersey False Claims Act
- Health Care Claims Fraud Act
- Conscientious Employee Protection Act

HNJH routinely discovers issues that require intervention and analysis. The various methods employed to aid in monitoring and identifying fraud, waste and abuse include daily queries, the SAS analytical software package, referrals from internal departments, external referrals (i.e. State Medicaid Fraud Unit, Pharmacy audit vendors, and fraud hotline) and media publications. HNJH’s Medicaid Special Investigations Unit coordinates fraud waste and abuse activities with all state and federal agencies.

If a potential issue is identified the information is reported to HNJH’s Medicaid Special Investigations Unit for evaluation and further action.

XVI. Compliance with State And Federal Regulatory and Medicaid Contract Requirements

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A. Confidentiality
The CQI process addresses sensitive protected health information about members and physicians. Documents that are created and reviewed as part of the CQI process are confidential and privileged. The information is maintained in compliance with appropriate federal and state regulations, the Health Insurance Portability and Accountability Act (HIPAA) and all applicable accrediting body standards. All employees, participating physicians, and consultants must maintain the HNJH standards of ethics and confidentiality regarding both patient information and proprietary information. All employees and non-employees are required to sign a confidentiality statement, as well as any consultant or business associate that may need to access confidential member information.

B. Member Rights, Responsibilities and Patient Engagement
HNJH is committed to maintaining a mutually respectful relationship with its members that promotes effective health care. HNJH makes clear its expectation for the rights and responsibilities of members and sets a structure for cooperation among members, practitioners and the health plan. HNJH recognizes that members must establish a dynamic partnership in the management of their care which includes the members’ family and their healthcare practitioner.
When care does not meet the member’s expectations, HNJH assures members of their right to voice complaints and to appeal any decisions with which they do not agree.

C. Regulatory Compliance
1. The Quality Management Department:
   • Monitors regulatory requirements for quality management and compliance;
   • Ensures that the appropriate actions are taken when areas of quality management non-compliance are identified.
   • Ensures HNJH’s quality management reporting system provides adequate information for meeting the regulatory external review and accreditation requirements of mandatory and voluntary review bodies.

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D. Ethics
The CQI Program functions as a key component in promotion of integrity and value found in the care and services provided to members. As outlined in the Horizon BCBSNJ Corporate Code of Business Conduct and ethics, HNJH is committed to maintaining the highest legal and ethical standards in the conduct of its businesses. In maintaining these standards, HNJH places heavy reliance on individual good judgment, honesty, and character. This commitment applies without exception to all activities.

XVII. Evaluation
The CQI program is evaluated annually. This evaluation parallels the CQI work plan and includes:

- A description of completed and ongoing CQI activities that address quality and safety of clinical care and quality of service.
- Evaluation and assessment of patient safety activities.
- Tracking and trending of data to assess performance in quality of care and quality of service.
- An analysis of improvements in quality of care and service to members.
- A critical assessment of barriers to achieving goals and root cause analysis.
- An evaluation of the overall effectiveness of the CQI Program.

The CQI Program evaluation is presented annually to the CQI Committee for review, comment and approval. The Vice President, Clinical Affairs, Chief Medical Officer, Horizon NJ Health also presents the CQI Program evaluation to the Horizon Healthcare of New Jersey Board of Directors on an annual basis with quarterly updates.
XVIII Approved by:

Manager, Quality Management

Medical Director
Chair Horizon NJ Health CQI Committee

3/17/14
Date

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